

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

07188

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
City or town Rural: ALLENS FRESH  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Bowling

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Hannie S. Bowling

## 7. Birth date of deceased (mo., da., yr.)

July 12, 1867

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

8113

hrs.

min.

## 9. Birthplace

Va.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Wallace Bowling

## 13. Birthplace

St. Marys Co. Md

## 14. Maiden name

Ellen Dooleman

## 15. Birthplace

Va.

## 16. Informant

## Address

Miss Annie Bowling  
Faulkner

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19 48Julia H. Pusey  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Rural: Allens Fresh  
(If outside city or town limits, write RURAL and give nearest town)Street No. -

(If rural, give LOCATION)

2. (a) If veteran, name war -

## MEDICAL CERTIFICATION

EST

20. DATE OF DEATH Sunday July 25, 1948 at 11:37 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1948 to 25 July 1948and that I last saw him alive on 25 July 1948Immediate cause of death Uremia, underlyingCause Destruction of the kidney substance  
because of increased pressure of the urine

## DURATION

Due to Enlarged Prostate64 years.

Due to

Other conditions Senile, arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. O. Woody, M.D.

M. D. or other

Address La Plata, Md.Date signed 25 July 48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Chas. Bowling, Sr.  
Ellen Fulk. Md.

RECEIVED

AUG 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

97

07189

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town Hughesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles  
 City or town Hughesville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ANNIE BRISCOE

## 3. (b) Social Security Number

4. Sex F 5. Color or race Col 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

Sept. 7, 1870

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 77 Months 10 Days 23  
 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Bryantown, Md.  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business \_\_\_\_\_

MOTHER  
FATHER

12. Name

Frank Farmer

13. Birthplace

Chas. co. Md

14. Maiden name

Rosie Jackson

15. Birthplace

Prince George Co. Md

16. Informant

Address

Edith Briscoe  
Hughesville, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

8/12/48  
(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Bryantown, Md

18. Funeral director

Address

Went & Ryan  
Wadsworth, Md.

19.

Aug 21 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3019 48, at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 119 48 toJuly 30 19 48

and that I last saw him alive on

July 30 19 48

Immediate cause of death

GANGRENE, ARTERIO-SCLEROTIC  
BOTH LEGS

DURATION

4 MONTHS

Due to

GENERALIZED ARTERIO-SCLEROSISUNKNOWN

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

John N. Griffin, M.D.

M. D. or other

Address

HUGHESVILLEDate signed 7/30/48

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

07190

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town En route to La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? En route  
 Hospital, institution, or retreat address where death occurred:  
D.O.A. Physician Memorial Hospital  
 How long in hospital or institution? D.O.A.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles  
 City or town Waldorf  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Charles Walter Delp

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

Oct. 31, 1936

8. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

11822

hrs.

min.

9. Birthplace

Washington D.C.  
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business \_\_\_\_\_

FATHER

12. Name

Walter Charles Delp

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Cora Mae Farrell

15. Birthplace

Newberg, Md.

16. Informant

Walter Charles Delp

Address

Waldorf, Md.

17.

Burial  
(Burial, cremation, or removal, which?)

Date thereof

7/24/48  
(month) (day) (year)

Cemetery or crematory

St. Pauls

Location

Waldorf, Md.

18. Funeral director

Hunt & Ryan

Address

Waldorf, Md.

19.

7-23-48  
(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22, 1948 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased onJuly 22, 1948 and that I saw him live on July 22, 1948

Immediate cause of death

Fractured base of skull

Due to

Auto accident

Due to

Rode bicycle into moving auto

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-22-48Where did injury occur? Waldorf Charles, Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) State highway #301Means of injury Rode bike into auto Injured at work? No

23. SIGNATURE

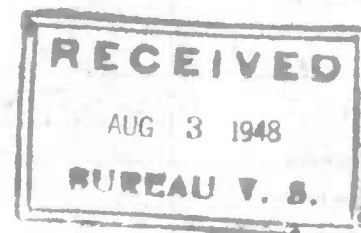
Jan. I. McKavanaugh, M.D.

M. D. or other

Address

La Plata, Md.Date signed 7-22-48

Deputy Medical Examiner



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

96

07191

705100

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... CharlesCity or town..... Hughesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date at  
deceased (mo., day, yr.) Sept. 17, 1883

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

64920

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

487-8St. Mary'sBryantown, Md.Hunt & RyanWaldorf, Md.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.County..... CharlesCity or town..... Hughesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 7..... 19.. 48..... at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

SEPTEMBER 30, 1947 to JULY 7, 1948and that I last saw him alive on JULY 7, 1948Immediate cause of death..... BRONCHO-PNEUMONIA(HYPOSTATIC TYPE)

DURATION

2 DAYSDue to..... PONTINE HEMORRHAGE7 MONTHSDue to..... CEREBRAL ANEURYSMUNKNOWN

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

John H. Griffin, M.D.

M. D. or other

Address.....

Hughesville, Md.Date signed..... 7/8/48

RECEIVED

JUL 14 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93dReg. Dist. No. 07192 100

## 1. PLACE OF DEATH:

County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Cecelia Lee

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Cal. 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Haris Lee  
 7. Birth date of deceased (mo., day, yr.) July 28, 1872 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 76 Months 2 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Charles Co., Md  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Hessie Adams13. Birthplace Chas. Co., Md.14. Maiden name Betty Adams?15. Birthplace Chas. Co., Md.16. Informant Bessie LeeAddress La Plata17. Burial Date thereof 8-3-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Burial ChapelLocation La Plata, Md18. Funeral director Huntt & RysonAddress Waldorf, Md.19. 8-2-48 19 Julia H. Pacey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 48 at 11:30 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 48 to July 31 19 48and that I last saw him alive on July 31 19 48Immediate cause of death Chronic myocardial degenerationDURATION ?Due to Chronic myocardial degenerationDue to Chronic myocardial degenerationOther conditions Amicula fibrillation 3-4 months

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John L. McKenney, M.D. Deputy Medical Examiner  
Address La Plata, Md Date signed 8-2-48

RECEIVED TO IMMIGRATION AT THE BUREAU

RECEIVED TO IMMIGRATION AT THE BUREAU

RECEIVED TO IMMIGRATION AT THE BUREAU

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07193

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County.....*Charles*  
 City or town.....*La Bonta*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*md.* County.....*St. Mary's*  
 City or town.....*Hermanville*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Lester Clifford Parson*

## 3. (b) Social Security Number

4. Sex

*M*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*Married*

6. (b) Name of husband or wife

*Lillian I. Parson*

7. Birth date of deceased (mo., day, yr.)

*Sept. 10, 1907*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

*40**9**26*

hrs.

min.

9. Birthplace

*Newmanstown, Pa.*

(Town, county, and state)

10. Usual occupation

*Fireman*

11. Industry or business

*Steam Power, N. J. C. Latent*

12. Name

*Lloyd H. Parson*

13. Birthplace

*Pa.*

14. Maiden name

*Emma Strickles*

15. Birthplace

*Pa.*

16. Informant

*Lillian I. Parson*

Address

*Hermanville, Md.*

17.

(Burial, cremation, or removal. Which?)

*Burial*

Date thereof

*7/18/48*

(month) (day) (year)

Cemetery or crematory

Location

*Rehrersburg Pa.*

18. Funeral director

Address

*Hunt & Ryan  
Waldorf, Md.*

19.

(Date rec'd by registrar)

*7/17*

19

*48**7/17**48**7/17**48*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*7-6*

19

*48*

at

*VP*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*5-4*

19

*48*

to

*7-6*

19

*48*

and that I last saw him alive on

*7-6*

19

*48*

Immediate cause of death

*In Toxemia*

DURATION

Due to

*Paralytic Ileus*

Due to

*Exsiccation*

Due to

*belonging (7 days) post  
abd. operation (Appendectomy)*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

*Appendicitis*

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Edelen M. I.*

M. D. or other

Address

*Fallate Rd*

Date signed

*7/17/48*

RECEIVED

JUL 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

07194

Reg. Dist. No. 105

## 1. PLACE OF DEATH:

County Charles  
 City or town Rural - Waldorf  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? About 10 days  
 Hospital, institution, or street address where death occurred: None  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Charles  
 City or town Rural - Waldorf  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harriet Pickens

## 3. (b) Social Security Number

4. Sex Se 5. Color or race R 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Jan 15 - 18-27 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 71 Years Months Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chas Co  
 (Town, county, and state)

10. Usual occupation house work

11. Industry or business \_\_\_\_\_

FATHER 12. Name James Pickens  
 13. Birthplace Chas Co Md

MOTHER 14. Maiden name Anna Bleas  
 15. Birthplace Chas Co Md

16. Informant Viola Pickens daughterAddress Waldorf Md

17. Burial St Peters Date thereof 7-6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waldorf MdLocation Waldorf Md

18. Funeral director Waldorf Md  
 Address Waldorf Md

19. July 6 1948 M. F. Monroe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 48 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 2 19 48 to July 3 19 48  
 and that I last saw him/her alive on July 3 19 48

Immediate cause of death apoplexyDue to Cerebral Hemorrhage

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results None Date of op. \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edwin D. Lane M.D.  
 Address Waldorf Date signed 7/6/48

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

189

07195  
705

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Charles  
City or town... East Island md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Wid

6. (b) Name of husband or wife

Dead

7. Birth date of

deceased (mo., day, yr.)

March 1869

8. AGE:

Years

Months

Days

If less than one day

79

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

Ret Saltzman

11. Industry or business

FATHER

12. Name

Murphy

13. Birthplace

Probably Germany

MOTHER

14. Maiden name

Murphy

15. Birthplace

Probably Germany

16. Informant

4317-Clayton-  
AddressCharles McChauly  
Byattsville

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial  
Fort Lincoln md

Location

Hammett & Son

18. Funeral director

Address

Waldorf md

19.

(Date rec'd by registrar)

19.

48

M. J. Edwards

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

approx 7 11

19.

48

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw h. alive on

19.

Immediate cause of death

Drowning

DURATION

approx 7-11-48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Coroner's Case

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

Patuxent River

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Patuxent River

Manner of injury

Injured at work?

23. SIGNATURE

E. J. EdwardsM. J.

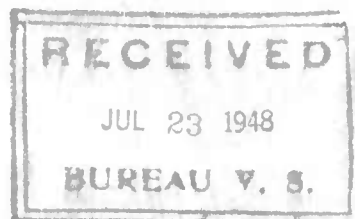
M. D. or other

Address

Lab late md

Date signed

7-15-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a

07196

Reg. Diat. No.

## 1. PLACE OF DEATH:

County CharlesCity or town Marshall Corner  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1227 Gilmore St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MelvinRogers

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Negro

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

1940

## 6.(c) If alive, give age..... years

## 8. AGE:

8

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Baltimore Maryland  
(Town, county, and state)

## 10. Usual occupation

Child

## 11. Industry or business

FATHER

## 12. Name

Phil Rogers

## 13. Birthplace

Md

MOTHER

## 14. Maiden name

Emma Marshall

## 15. Birthplace

LaPlata Maryland

## 16. Informant

Emma Rogers

## Address

1227 N. Gilmore St

## 17.

Funeral, cremation, or removal (Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19 8-87/101948AW. HedrickReg.Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 48 at 2 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8th 19 48 to July 8th 19 48 and that I last saw him alive on July 8th 19 48

## Immediate cause of death

Accidental Death

## Due to

Broken Neck

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-8-48Where did injury occur? Marshall Corner Charles, Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Fall from Tree Injured at work?

## 23. SIGNATURE

Percival C. Smith

M. D. or other

Address Indian Head Md Date signed 7-8-48

1946

8

1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

07197

### 1. PLACE OF DEATH:

County Charles  
City or town Rural La Plata  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
none  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Charles  
City or town Rural La Plata  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Spring Hill  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

NANNIE THOMAS

### 3. (b) Social Security Number

4. Sex female 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband FRANK THOMAS  
6. (c) If alive, give age deceased years  
7. Birth date of deceased (mo., day, yr.) JULY 4, 1860  
8. AGE: Years 88 Months 0 Days 0 It less than one day - hrs. - min.

9. Birthplace Port Tobacco, Char. Co. Md.  
(Town, county, and state)

10. Usual occupation House wife

### 11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name Hannet Wood

15. Birthplace Char. Co. Md.

16. Informant daughter: Mary Sellers

Address 1921 Rosedale St. N.E. Wash. D.C.

17. Burial Date thereof 7-8-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Ignatius

Location Bil Altam ind

18. Funeral director Hunter & Son

Address Wardway 2nd

19. 7/7 19 48 Julius H. Pusey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

EST

20. DATE OF DEATH July 3<sup>rd</sup> 1948 at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased 10 January 1948 to July 2 1948

and that I last saw her alive on 20 July 1948

Immediate cause of death Cerebral vascular accident

### DURATION

3 hrs.

Due to Anterior chain 20 yrs.

Due to Senile degeneration 13 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Wooddy M.D.

Address La Plata. Md. Date signed July 48

MARGIN RESERVED FOR BINDING

I

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 10 1948

BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County CharlesCity or town Benedict  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CharlesCity or town Benedict  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rose O. Thompson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Cal.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Frank Thompson

7. Birth date of deceased (mo., day, yr.)

June 10, 1886

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

62-26

hrs.

min.

9. Birthplace

Charlton, W. Va.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Harry Lee

13. Birthplace

W. Va.

14. Maiden name

Eliza Lee

15. Birthplace

W. Va.

16. Informant

Address

Frank Thompson  
Benedict, Md.

17. (Burial, cremation, or removal, Which?)

Date thereof

7-6-48  
(month) (day) (year)

Cemetery or crematory

Washington D C

Location

18. Funeral director

Address

Melvin & Selley Inc.  
424 R St. N. W. Wash D C

19.

7-6  
(Date rec'd by registrar)

19

48John H. Poy  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6

19

48

at

9 A

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on July 6, 1948 to 1948and that I ~~had~~ saw him ~~live~~ on July 6, 1948

Immediate cause of death

Carcinoma of stomach

DURATION

1 yr +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

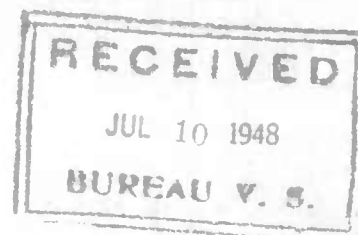
23. SIGNATURE

John E. Mark  
Deputy Medical Examiner  
John E. Mark  
M. D. or other

Address

Date signed

7-6-48



5194